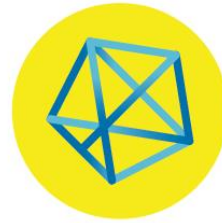


ALL IN



DATA FOR
COMMUNITY
HEALTH

Hospital System Partnerships: Starting with the Community

Communities Joined in Action, April 2019



Speakers

Janina Lord Morrison, MD, MPH
Division of Chronic Disease and Injury Prevention
Los Angeles County Department of Public Health

Camilla Comer-Carruthers, MPH
Robert Wood Johnson University Hospital

Moderator

Clare Tanner, PhD
Data Across Sectors for Health
At the Michigan Public Health Institute

Learnings

- » Using data to tell the story of community health needs and assess effectiveness
- » Implementing with a focus on data collection, sharing, and application
- » Being part of a growing national learning community

ALL IN



The BUILD
Health
Challenge



Data Across
Sectors for
Health



The Public Health
National Center
for Innovations



New Jersey
Health
Initiatives



Population
Health
Innovation
Lab



Community
Health Peer
Learning
Program



Connecting
Communities
and Care

All In: Mission and Goals



Support the growth and sustainability of a movement acknowledging health as a product of social, economic, environmental, and behavioral forces.



Build an evidence base to advance the field of multi-sector data integration and sharing to improve community health.



Harness the power of peer learning and collaboration to extend our impact by accelerating sharing of insights, lessons learned, and resources.

What we talk about when we talk about multi-sector data



Two Broad Aims for Data Sharing



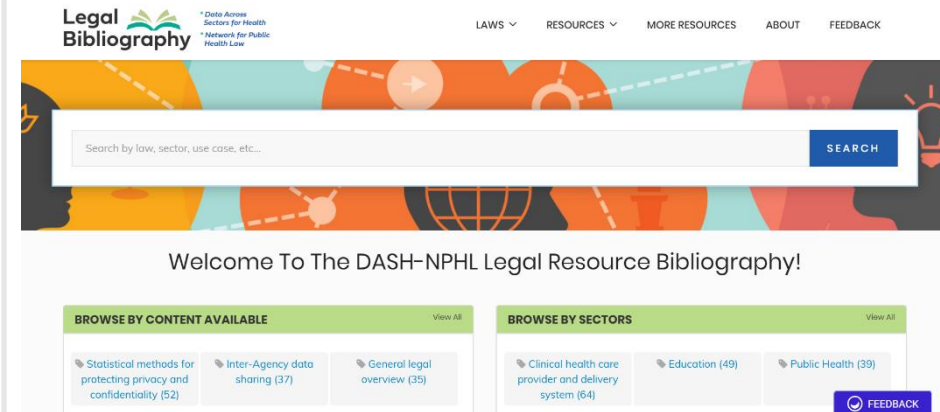
Whole Person Systems of Care



Place-based System, Policy, and Environmental Change

An Offer and an Ask

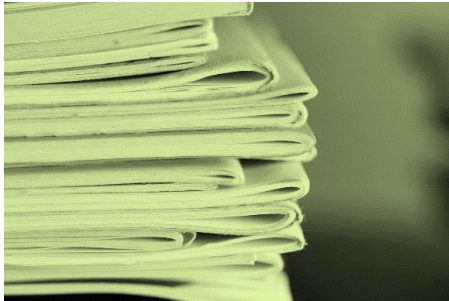
- » Offer: The DASH-NPHL Bibliography
 - » Legalbib.communitycommons.org
- » Ask: The National Inventory of Data-Sharing Collaborations for Health
 - » www.tinyURL.com/NationalInventory



2019 National Inventory of Data Sharing Collaborations for Health

All In Learning Network

Publications



Online Platform



Peer Site Visits



Webinars



Newsletters



National & Regional Meetings and Workshops



All In Online Community

allin.healthdoers.org



Continue the conversation



Access resources



Connect with peers



Events calendar

Tips to get started:

- » Complete your individual member profile
- » Contact info@allindata.org to add a project profile or create your own
- » Attend an *All In Office Hours* session for an in-depth tour





NEW BRUNSWICK HEALTHY HOUSING COLLABORATIVE

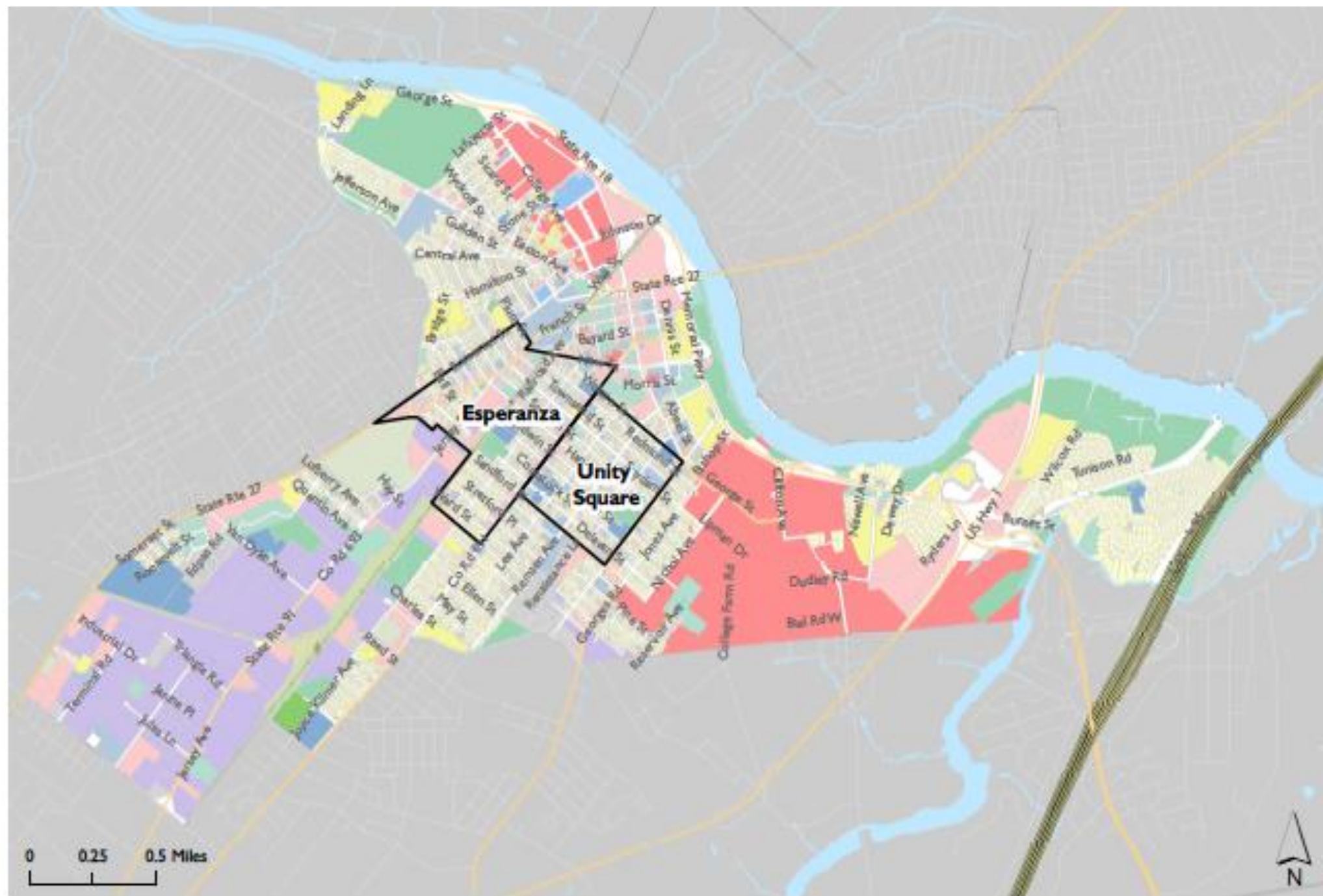


Improving Health Through Innovative Collaborations

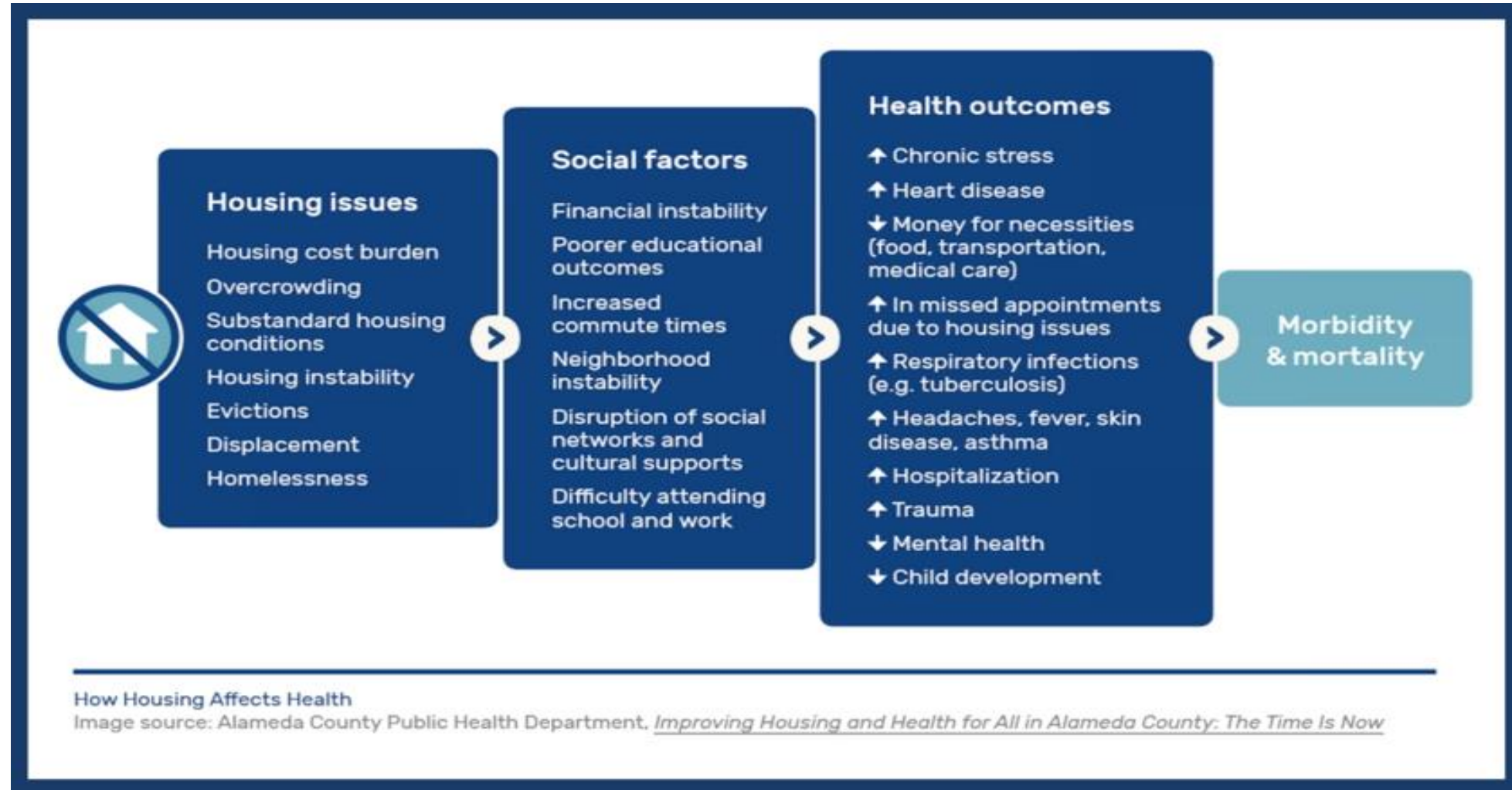
**Robert Wood Johnson
University Hospital**

**RWJBarnabas
HEALTH**

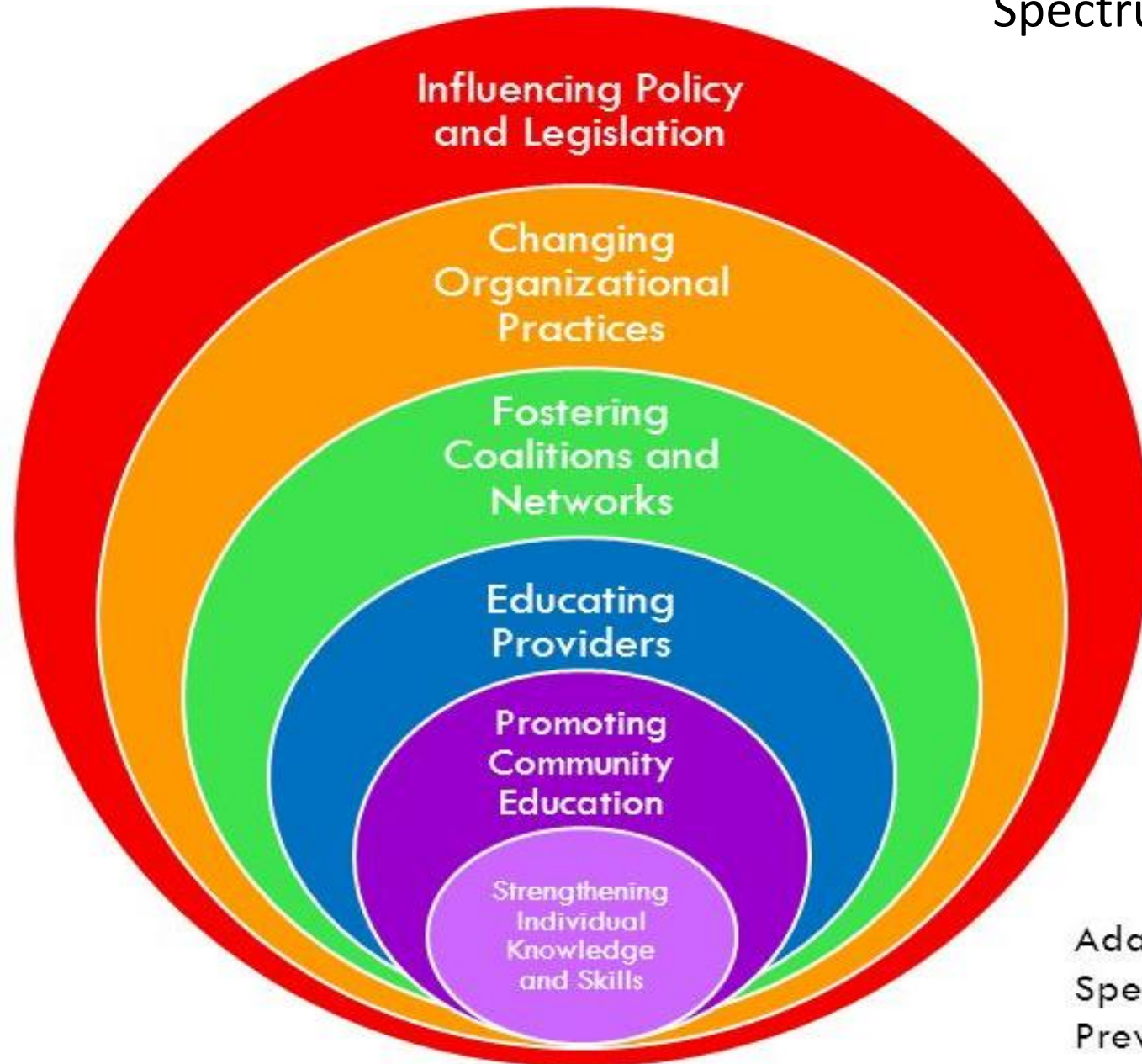
Let's be healthy together.



BUILD Health Challenge 2.0

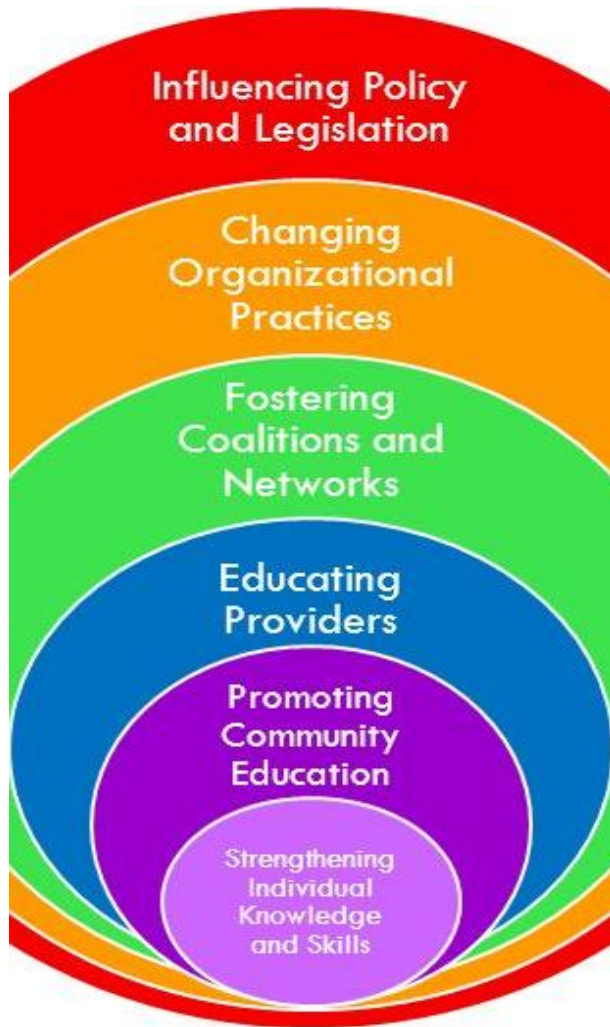


Spectrum of Prevention / Intervention



Adapted from:
Spectrum of Prevention,
Prevention Institute

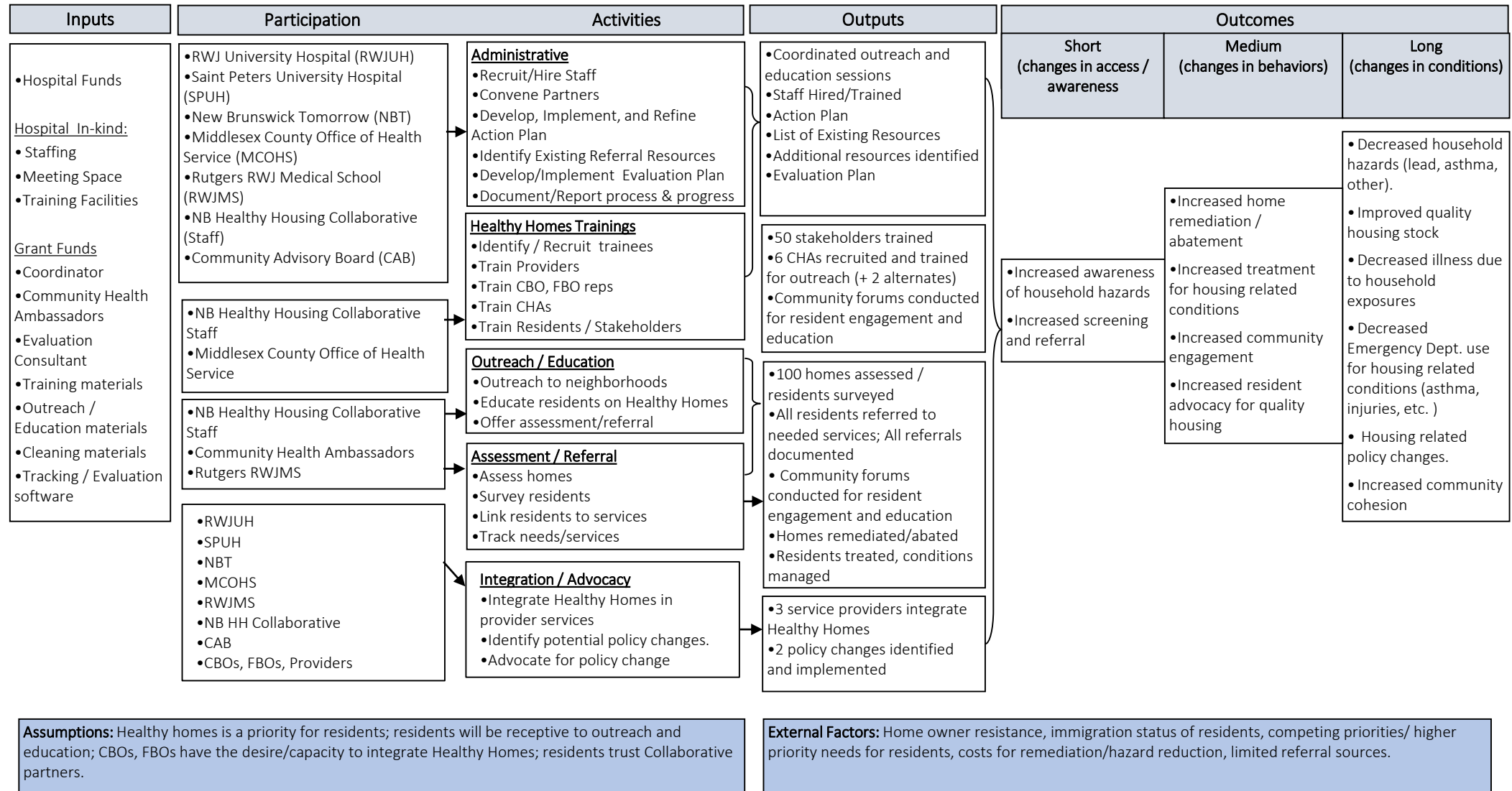
Spectrum of Prevention / Intervention



Objectives	Strategies and Actions
Develop strategies to change laws and policies to influence outcomes in health and safety.	<ul style="list-style-type: none"> Engage residents in advocacy activities. Support City healthy housing initiatives.
Adopt regulations and procedures to improve health and safety and create new standards for organizations.	<ul style="list-style-type: none"> Support system changes at neighborhood projects and CBOs. Support system changes within health systems.
Bring together groups and individuals for broader goals and greater impact	<ul style="list-style-type: none"> Engage residents within target communities. Identify areas of need and shared vision. Address barriers to care issues and healthy living.
Inform providers who will transmit skills and knowledge to others and/or become champions or advocates for the cause.	<ul style="list-style-type: none"> Educate landlords on healthy housing principles. Engage local health providers.
Reach groups of people with information and resources to promote safety or to prevent unhealthy practices.	<ul style="list-style-type: none"> Engage CBOs in healthy homes discussions. Recruit Community Health Ambassadors (CHAs). Provide training and education. Assess homes and individuals.
Enhance an individual's capacity to avoid unhealthy behaviors and environments.	<ul style="list-style-type: none"> Provide information on health and housing. Link residents to supportive services and resources. Support residents in healthy homes promotion.

Camilla Comer-Carruthers, MPH and Mariam Merced, M.A
Robert Wood Johnson University Hospital, New Brunswick

Situation: Building on the collaborations and partnerships of the Healthier Middlesex's Community Health Improvement Plan and the Healthier New Brunswick Blueprint for Action, the partners will launch the New Brunswick Healthy Housing Collaborative to ensure that all New Brunswick residents live in safe homes that facilitate healthy living.



BASIC TENANT & LANDLORD RESPONSIBILITIES

TENANT

- Paying the full amount of rent on time.
- Preventing damage on the rental premises.
- Repairing damage caused by tenant or someone the tenant has allowed on the premise.
- Following the rules laid out in the rental agreement form.
- Not performing or conducting illegal activities on the property.
- Contacting the landlord as soon as possible when a serious problem arises involving repairs or services.

LANDLORD

- Maintaining common areas such as the driveway.
- Making sure that the property is habitable (in other words pest-free and in good state of repair), complying with health, safety, housing and maintenance standards.
- Not intruding on the tenant's premises beyond what is necessary to fulfill landlord responsibilities.
- Providing 24 hours notice to tenant(s) when planning to enter the premises.
- Ensuring there is access to vital services like heat, water and electricity.

PARTNERSHIPS FOR PROGRESS

Core Partners:



Community-Based Partnerships:



PARTNERS IN YOUR
LIFE'S JOURNEY



Community Health Ambassadors





Hospital Systems Partnerships: Starting with the Community

Case Study: The Wellness Center at the Historic General Hospital

Communities Joined in Action
April 26, 2019

Janina Lord Morrison, MD, MPH

Medical Director, The Wellness Center at the Historic General Hospital
Director, Clinical and Preventive Services, Chronic Disease and Injury
Prevention, Los Angeles County Dept of Public Health

Janina@thewellnesscenterla.org

JMorrison@ph.lacounty.gov



I have no conflicts of
interest to report

Goal/Objectives

Goal: to describe the design and implementation of a Wellness Center model for community-clinical linkages at a large safety-net medical center, with focus on data-sharing

Objectives:

By the end of this session, you will be able to:

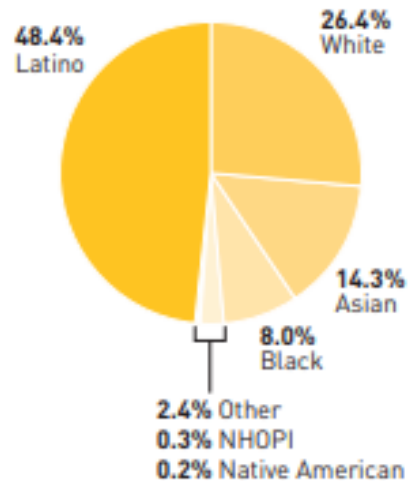
1. List three types of outcome data that can be shared through a collaborative effort to provide community-based services in collaboration with clinical care
2. Describe two challenges to data sharing between healthcare providers and community-based organizations working to provide holistic care to address the social determinants of health



Study Setting and Population



Population of LA
County's Major Racial
and Ethnic Groups



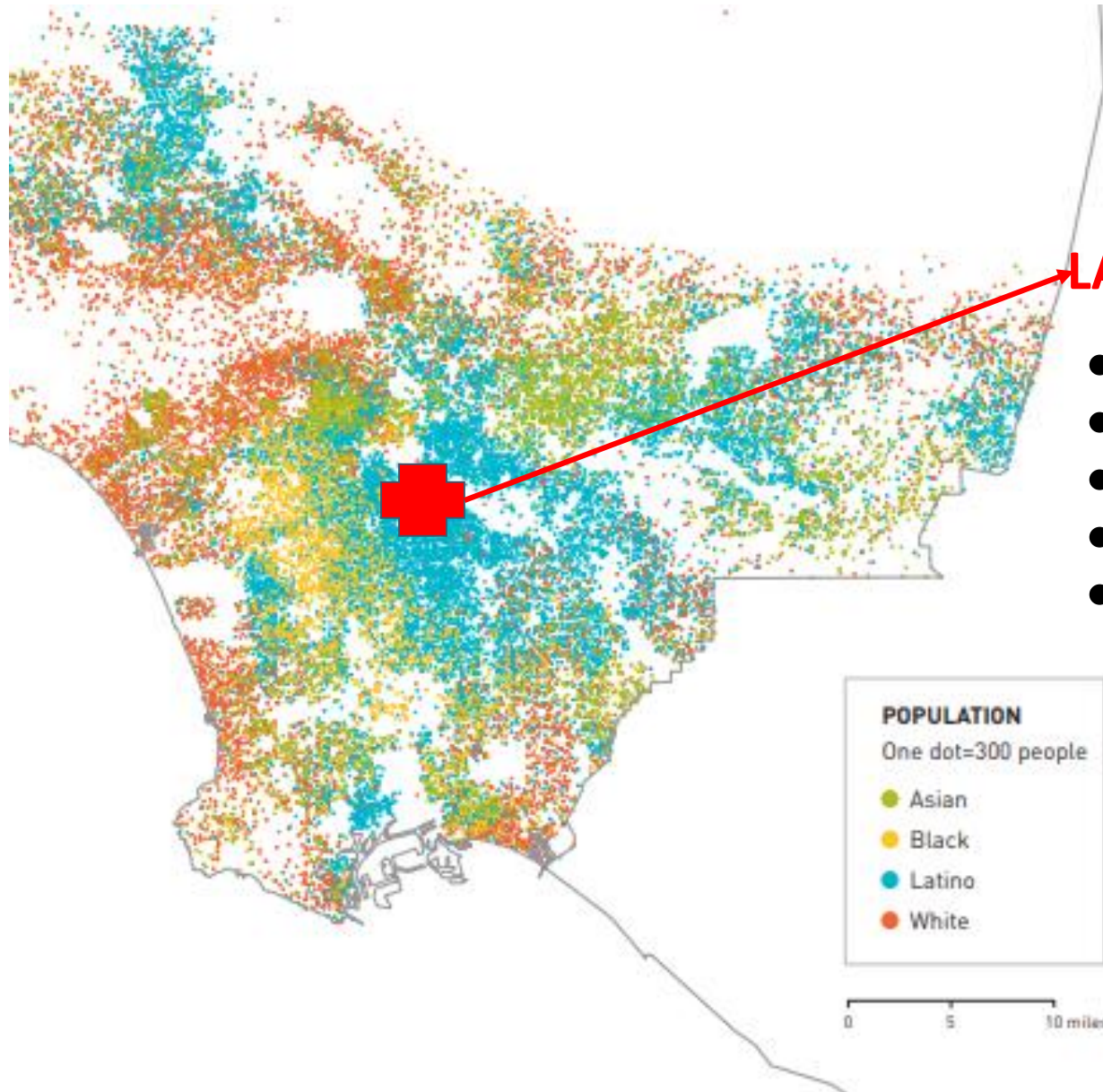
Source: US Census Bureau ACS,
2015.

65%
NATIVE-BORN

35%
FOREIGN-BORN

The County Department of Health Services (DHS) sees nearly 500,000 patients each year at its hospitals and clinics, with 380,000 empaneled for comprehensive primary care services

Study Setting and Population




LAC+USC Med Ctr

- 600 beds
- Level 1 Trauma
- 150,000 ED visits yearly
- Proximity to Skid Row
- “Historic” General Hospital







What is the wellness center?

A one-stop destination for health and wellness

- 40,000 square-feet of indoor space on the campus of LAC+USC medical center
- Classrooms, meeting rooms, indoor and outdoor event spaces
- A fully-equipped YMCA fitness center
- Outdoor fitness area, fitness walk, and playground
- Family room with childcare and programming for kids



Everyone is welcome! All services provided free of charge. Only YMCA Gym membership.

TUES	WED	THURS	FRI
14 10:00 am – 11:00 am Multiple Sclerosis: Workshop for Newly Diagnosed – Suite 1031 (E&S) 10:00am-11:00am Senior Health Education Class Suite 1072 (E&S) 1:30 am – 12:30 pm erobics for Seniors Dance Studio 00 pm – 2:00 pm ga - Dance Studio	15 10:00 am – 12:00 pm Early Learning Readiness Program – Family Room 10:30 am – 12:30 pm Diabetes Self- Management Group: Health & Flavor in the Kitchen – Suite 1021* (S) 11:00 am – 12:00 pm Tai Chi for Seniors – Dance Studio 12:30 pm – 1:30 pm Dance Fitness (<i>Limit</i> 30) -Dance Studio 1:00 pm – 2:00 pm Mental Health Self- Advocacy Support Group - Conference Room 2 (S)	16 10:00 am – 11:00 am Multiple Sclerosis: Workshop for Newly Diagnosed – Suite 1031 (E&S) 10:30am – 11:30am Adaptive Zumba for People with Varying Abilities – Dance Studio 12:00 pm – 1:00 pm Yoga - Dance Studio 5:00 pm – 6:00 pm Fitness Yoga - Dance Studio	17 10:00 am – 12 Healthy Cooking – Demonstration Kitchen (S) 10:00 am – 12: Health & Benefi Advocacy Legal – Suite 1014 (E& 10:00 am – 12:0 Resume Writing Workshop (PLEASE RSVP) – MPR 1072 (E)* 1:00 pm – 2:00 p Adelante/ Moving Forward Cancer Survivorship Fitne Class – Limit 15 – Dance Studio (E 1:00 pm – 3:00 pm

A dance/exercise studio



A demonstration kitchen

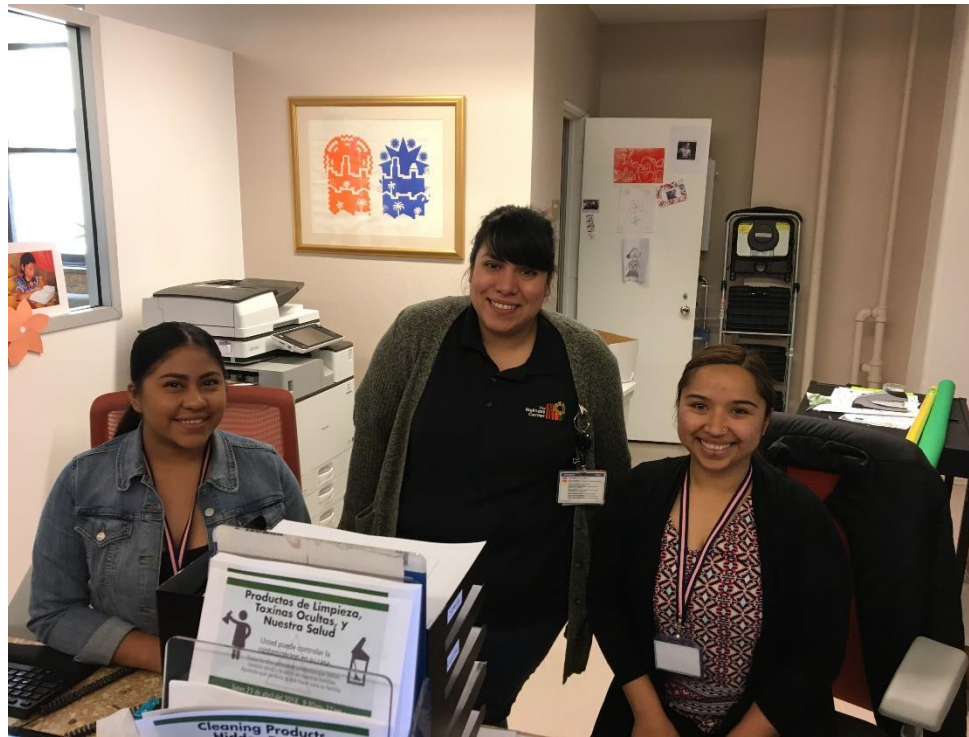


The true stars of TWC....

- 23 community-based organizations with offices within TWC
- 7 hubs:
 - Chronic Disease Management and Prevention
 - Integrative Health, Pain Management and Mobility
 - Healthcare Enrollment and Legal Advocacy
 - Trauma-informed Care and Mental Health
 - Housing and Food Insecurity
 - Youth development
 - Community organizing and policy advocacy

But providers do not have to remember all of this...

The Wellness Center is staffed
by a team of *Wellness
Navigators*



Their responsibilities include....

- Intakes
- Referrals and navigation of resources
- Outreach/Satellite Desks
- Evidence-Based Programs
- *So much more...*



The Wellness Center— Our Services

Each client creates their own tailored bundle of services appropriate to their needs, including....

1. Evidence-Based Programs

Mental health counseling for mild-moderate mental illness, Chronic Disease self-management, Diabetes prevention, Chronic Pain self-management, Exercise for arthritis, Tobacco cessation, Fall prevention

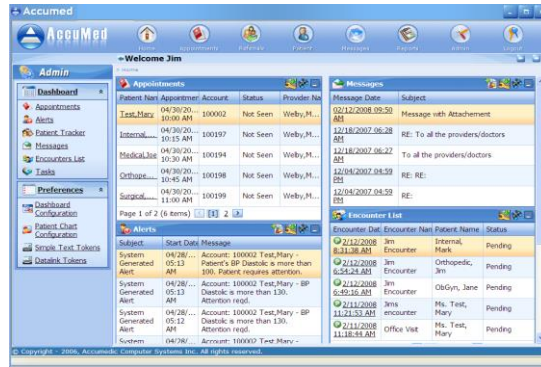
2. Supplemental one-on-one services

Healthcare enrollment, Legal advocacy, Immigration advocacy, Acupuncture, YMCA membership, Dietician, Produce Distribution

3. Supplemental group services

Exercise classes, yoga classes, cooking classes, support groups, health education classes, youth development programs

Data Collection and Evaluation



Electronic Medical Record

- referral flyer
- diagnosis
- utilization

TWC intake

- demographics
- screening
- referrals



CBO utilization and follow-up

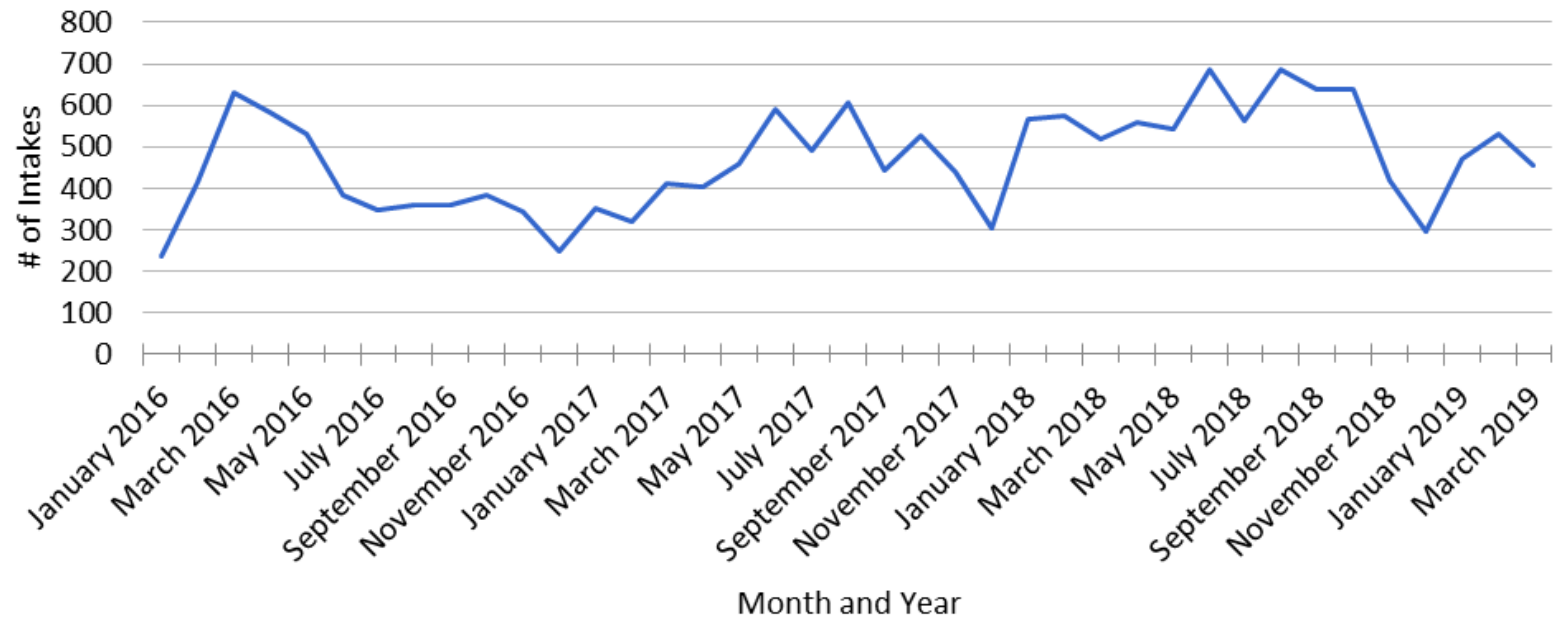
Community
Based
Organization

Results

The Wellness Center opened in April, 2014

By January 2016, we were offering a fairly consistent menu of services to a steady stream of clients

Wellness Center intakes per month from January 2016 through March 2019



Demographics

Characteristics of Clients	FY2017-2018 (n=6255)	FY2018-2019 (to date) (n=4702)
Average age	44 years	45 years
% female	54%	47%
% Spanish speaking	58%	50%
% Latino	77%	68%
% living within 5 mile radius	56%	54%
% Diabetes	15%	14%
% with at least 1 hospitalization	13%	13%
% with at least 1 ED visit	47%	56%

Results

- Where do the clients come from?
- 62% referred from the adjacent medical center:
 - 42% from the ED,
 - 20% from other providers;
- 17% report their PCP is at the medical center
- The rest are referred through friends/family or other community organizations

Results: A monthly snapshot

What services do our clients receive?

- 493 receive healthcare enrollment assistance
- 58 receive legal services
- 300 in therapy
- 133 receive advocacy for mental health services or domestic violence/sexual assault
- 4845 exercising, 1000 in cooking classes
- 20 in evidence-based programs for chronic disease management
- 240 receive free produce
- 86 receive assistance with food stamp enrollment
- 80 acupuncture sessions

Discussion

Limitations/Obstacles

1. Challenges in linking various data systems
2. Additional challenges sharing data for privacy-sensitive services
3. Difficult to capture the variety of services offered
4. Different audiences want different outcomes

Discussion

Next steps

1. TWC data can be linked to medical record data from the LA County EHR to track health outcomes and utilization before and after TWC intervention
2. First budget proposals under review by Los Angeles County to provide sustainable funding for navigation services by funding Navigator positions
3. New grant-funded initiatives to expand trauma-informed services for mental health (DMH), homelessness (Whole Person Care), chronic disease management and prevention (CDC), and immigration advocacy (RWJF)

Acknowledgements

- **The Wellness Center is a project of The LAC+USC Medical Center Foundation**, an independent 501(c)(3) non-profit organization.

Thanks to...

- The Wellness Navigator team!
- The executive and administrative staff of The Wellness Center/LAC+USC Medical Center Foundation
- All our community partners
- Our clients!

Questions/Discussion